STATE OF INDIANA)
) SS:
COUNTY OF MARION)

IN THE SUPERIOR COURT OF MARION COUNTY

YVONNE ROGERS, Individually)
and as Executrix of the Estate)
of Richard Rogers, Deceased,)
)
Plaintiffs,)
)
-vs-) CAUSE NO.
) 49D02-9301-CT-0008
R. J. REYNOLDS TOBACCO CO.,)
et al.,)
)
Defendants.)

REPORTER'S TRANSCRIPT OF PROCEEDINGS

BEFORE: HON. KENNETH H. JOHNSON, JUDGE

VOLUME I
February 8, 1995
Morning Session

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(WITNESS - WOODROW MYERS, M.D.)

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(The trial proceedings commenced at 9:05 a.m., Wednesday, February 8, 1995, the Honorable Kenneth Johnson presiding.)

(The following proceedings were conducted out of the presence of the jury.)

MR. WAGNER: Your Honor, your Honor entered a motion, or an order on January 23, 1995, concerning the exclusion of cumulative expert testimony.

The witness who I believe is going to be first called this morning by the plaintiffs is Dr. Myers. Dr. Myers' 26(b) disclosure states that he is going to testify that cigarette smoking causes lung cancer, Richard Rogers' cigarette smoking was the cause of lung cancer, and cigarette smoking is addictive.

I believe, your Honor, we have had at this point tons of testimony on those subjects. Dr. Myers cannot bring anything to this courtroom or to this jury that they haven't heard for the last several days of testimony through both Dr. Burns and Dr. Jay.

And we would, therefore, ask the Court to

exclude this repetitious and cumulative testimony from Dr. Myers.

One other matter is that we anticipate that Dr. Myers, if he is allowed to testify, and we don't believe that he should, but that if he does, that he will attempt to testify that Richard Rogers was addicted, and that, also -- that is not within his 26(b) disclosure.

So, we move, first of all, that his testimony be excluded in toto because it is cumulative and should be barred by the Court's previous order entered in this case; and, secondly, that if he is allowed to testify, he not be allowed to testify any opinions as to Richard Rogers' addiction for the reasons stated.

THE COURT: We'll let the plaintiffs respond here, but one of the reasons that we have -- that you suggested and I agreed that we would have a 48-hour disclosure so these matters can be taken up in the evening. This is not the kind of matter I want to take

up at 9 a.m. while I have a jury in the room. This is exactly why predisclosure so -- just in terms of functions, this is the kind of thing I want you to bring up the night before, not after you've had a night to think about it and several days. But that's exactly why we do it like this, so that I don't have a jury in the room waiting for us to take up arguments on matters that you knew would -- you knew all this last night, so --

In any event, the motion is made and I will let the plaintiffs respond.

MR. HARDY: Your Honor, could I say something before the plaintiffs respond?

THE COURT: Sure.

MR. HARDY: I just want to clarify things for the record of this trial. Philip Morris joins in the objection, and I did want to clarify. Is it necessary for us, on objections for the other defendants, to indicate that they join in the objections or can we have an understanding that if one defendant objects, that the objection stands as

to all defendants?

THE COURT: I wouldn't have any problem with a standing rule like that. Obviously it makes for better decorum and procedure that not all four -- counsel for all four defendants need to make an objection. And I would certainly have no problem with a standing -- with the understanding that when one defense counsel makes an objection, that the others join in it, perhaps, unless -- I guess I can't hypothecate something in my own mind that there would be some particular objection that somebody would not want to join in, but I don't have any problem with understanding that all defendants join in the objection.

And, matter of fact, I understood it, and that has been I think how we've been proceeding with that understanding.

MR. HARDY: I believe so, but I just want to be sure.

THE COURT: If there's additional grounds for objections, certainly another

counsel can asked to be recognized to state an additional grounds for exclusion or an objection, and certainly that's appropriate. I certainly don't have any problem with that understanding.

Let the record show that that's all of our understanding, that when one defense counsel makes an objection, all the others join in without specifically each time having to say so.

Plaintiffs' response to the motion for exclusion of the testimony of Dr. Myers.

MR. MICHAEL HOLLAND: Thank you. Dr. Myers comes at this question from his own experience, his own background and specialty, particularly with his background and training and experience in the field of public health, that's the context in which he has addressed the issues. We have only had two witnesses who have testified, thoracic surgeon and pulmonologist. And Dr. Myers approaches these questions from his own area of expertise.

With respect to Richard Rogers' addiction,

we do not intend to ask him specifically about Richard Rogers' addiction and that is not an area we intend to conduct examination with him.

THE COURT: What's the other area that he brings, he's going to talk about? Dick said addiction. What else was it, addiction and --

MR. WAGNER: The 26(b) disclosure, Judge, cigarette smoking causes lung cancer, Richard Rogers' smoking was the cause of his lung cancer, and cigarette smoking is addictive.

THE COURT: That's the 26(b) disclosure, which of those is he --

MR. MICHAEL HOLLAND: We intend to ask him about the fact that cigarette smoking causes lung cancer and that it's addictive.

THE COURT: But just not with Richard Rogers?

MR. MICHAEL HOLLAND: We don't intend to bring in Richard Rogers.

THE COURT: It is not a topic

we've not ventured into. I mean, the point is that it is cumulative and we have had discussions in all -- in several days of trial about two times is actually cumulative, but when does it become cumulative to the point of exclusion, and so this will be the third witness to testify as to two of those points; right?

MR. MICHAEL HOLLAND: He will, but, I mean, those are central points. And I think the fact that we have experts that are coming from separate fields of expertise, he has his own experiences with respect to diagnosis and treatment of people that have cancer. He has his own experiences concerning contact and treatment of people who are addicted. And he brings those to bear and I think they are important for the jury's consideration.

THE COURT: Are there other witnesses that the plaintiff plans on calling to cover these same topics?

MR. MICHAEL HOLLAND: There may

be, but there may not be. We are aware of the cumulative --

THE COURT: So the answer is yes and no?

MR. MICHAEL HOLLAND: Well --

THE COURT: Maybe?

MR. MICHAEL HOLLAND: Maybe.

THE COURT: Definitely maybe?

MR. WARREN HOLLAND: It's a 48 hour-48 hour question, your Honor.

THE COURT: I've still not gotten any note of any 48-hour disclosures to me, so it's --

I am going to overrule the objection and allow the witness to testify.

Any other motions?

Just procedurally, let me just emphasize it again, those are the kinds of motion with a prior disclosure requirement that I want made the night before so that we can take those up and discuss those so we can have -- so I feel like I've had sufficient time to consider the motion and to examine it. And if I had that

motion made last night, I might have wanted, perhaps, to consider it further, but it is the kind of thing that I do want you to make, please, the night before. That's what we're here for.

I've restructured my life like you've restructured yours. This is it. This is what I do from now till whenever we get finished. Just like you have made special provision to be here. So these are the kind of things that I expect you to raise the night before.

I think with that, though, having handled that motion, we're ready to bring the jury in, please, and plaintiff's next witness.

(The jury entered the courtroom at 9:14 a.m.)

THE COURT: Jury may be seated. Good morning. Everybody okay? Hanging in there all right? You started redecorating the jury room yet? That coming? Carpet and curtains are coming, I can feel it.

For the record, plaintiffs call the next witness, please.

MR. MICHAEL HOLLAND: Plaintiffs call Dr. Woodrow Myers.

(At this time the witness, Dr. Myers, was sworn in by the Court.)

WOODROW A. MYERS, JR., M.D.,

having been called on behalf of the plaintiff, having been first duly sworn to tell the truth, the whole truth and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION,

QUESTIONS BY MR. MICHAEL W. HOLLAND:

Q Could you state your name, please.
A Woodrow Augustus Myers, Jr.
Q And where do you live?
A Indianapolis.
Q What is your profession?
A I'm a physician and I am the corporate medical director of The Associated Group in Indianapolis, and I'm also the corporate medical director of one of its subsidiaries called Athena of North America.
Q Could you explain what your responsibilities

are in your current position?

A There are a variety of responsibilities. As corporate medical director for the parent company of The Associated Group, I'm responsible for responding to any issues that are medical in nature, especially those issues for which there is some external interest. Typical example might be the debate regarding health care reform.

In my role with Athena of North America, my job is to manage a strategic business unit within that corporation whose major responsibilities are medical information systems, looking at health care outcomes, looking at guidelines for medical care, looking at the quality of medical care, looking at profiles of physicians and other providers, and providing those to other subsidiaries within our company and to some external hospitals, doctors' practices and so on.

Q Are you married?

A Yes.

Q Do you have children?

A I have two children.

Q Can you tell us your educational background, please?

A I was -- I finished grade school here in Indianapolis in IPS. I was a -- finished high school at Shortridge High School back in the days when it was a high school before it became a junior high, at 34th and Meridian. I left high school to attend Stanford University, where I received my bachelor's degree in science with a major in biology in 1973. I then attended medical school at the Harvard Medical School in Boston, Massachusetts, where I received my M.D. degree in 1977.

After medical school I completed an internship in internal medicine at the Stanford University Medical Center in California, followed by a residency in internal medicine at the same institution, followed by a fellowship in critical care medicine in the intensive care units at Stanford University Medical Center.

I also completed a fellowship in health care policy. It was a combined program at

Stanford University and the University of California, San Francisco, and I followed that with a master's in business administration that I received from the Stanford University School of Business.

Q During the course of your medical training, did you have occasion to become actively involved in the treatment of patients?

A Yes.

Q And then when you were obtaining your M.B.A. and thereafter, did you also remain involved in the treatment of patients?

A Yes.

Q Can you explain that a little bit?

A I did my M.B.A. degree simultaneously with my fellowship in critical care medicine, so I was actively practicing in the I.C.U.s and Stanford's emergency room and some other emergency rooms around the Bay area trying to make some extra money from my little -- when I had my kids.

Then when I finished my fellowships, I took a position on the faculty at the

University of California, San Francisco. I was assistant professor of medicine there, and I was also the quality assurance chairman for San Francisco General Hospital. San Francisco General Hospital is a county hospital in San Francisco, it's the trauma center for San Francisco County. There were four of us that ran the medical surgical I.C.U., I was one of those physicians.

In addition to the role that you have in I.C.U., when you're on the faculty in that role, you also see patients on the medical wards, you lead teams of interns and residents and nurses on the wards. I did that. I also had clinical responsibilities in the San Francisco medical clinics and in the emergency rooms. I would see patients there as well.

In my spare time I had a part-time weekend position at Oakland Hospital in Oakland, California.

After I left San Francisco and after a stint as the physician health adviser to the Senate Committee on Labor and Human Resources

in Washington with Senator Ted Kennedy, I came back to Indiana. After then Governor Bob Orr asked me to be health commissioner for the State of Indiana, a position I held for five years. I was health commissioner four years with Bob Orr and one year with Governor Evan Bayh.

During that time I was an assistant professor of medicine at the Indiana University Medical Center, and my clinical role was that of a attending physician in the emergency medicine at Wishard Hospital, which I did part-time during that period of time.

In 1990, I left Indiana for about a year and three-quarter stint in New York City where I was health commissioner for the City of New York with then Mayor David Dinkins.

During that period of time, I did not actively practice medicine as I had as commissioner of Indiana, but I did have my license to practice in New York. And I did little things on the side for some employees and friends, but I never formally practiced in

any clinical setting during that about a year and three-quarters.

In August of '91, I came back to Indiana where I took the position that I just described as corporate medical director for The Associated Group, and I was reinstated at my prior faculty position at I.U. Medical Center, but they gave me a little bit of a promotion to clinical associate professor of medicine. And they gave me my old job back in the Wishard E.R. where I see patients with the interns and residents and medical students on a regular basis.

Q Doctor, with the exception of that time frame when you were health commissioner in the City of New York, have you continued to see patients since the time of your medical training?

A Yes.

Q And you currently continue to see patients at Wishard?

A I do. In fact, my last stint was last Friday. And I will be there two days from now, Friday -- this coming Friday.

Q Are you certified, board certified in any fields of medicine?

A Yes, I am.

Q In what fields are those?

A I am board certified in internal medicine by the American Board of Internal Medicine. I received my board certification in medicine after I finished my I.C.U. fellowship, or while I was completing my I.C.U. fellowship. And I'm also board certified in medical management by the American College of Physician Executives. And I got that I think sometime in the early '80s.

Q What's involved in board certification?

A There are a number of prerequisites before you're allowed to sit for the board certification examination.

For the -- in internal medicine, you have to have completed an internship and residency at an accredited medical center. You had to have good reports from your faculty and the recommendation from the faculty that you're allowed to sit for the boards. You have to

have had a fairly clean record while you're a resident.

And then once you're allowed to sit for the boards, it's a half a day examination, multiple choice, and clinical scenarios, and different kinds of questions that you have to answer and you have to get a high percentage of those right. And then they mail you back a certificate saying whether you passed the examination or not.

In the case of the American Board of Medical Management, there are similar kinds of prerequisites including completion of a residency program. In addition, you had to have significant experience as a manager within a medical setting.

My qualifications to sit for that board included the fact that I was chairman of the quality assurance program at San Francisco General Hospital for two and a half years, which meant that I was responsible for engineering all of the inspections of the hospital by the Joint Commission on

Accreditation of Hospitals by the State Department of Health and by other accrediting bodies. I was responsible for making sure that the credentialing files in the hospital were in shape, that the governing body regulations were appropriately set and so on.

That experience allowed me to sit for the boards for the American Board of Medical Management and I received my board certification after I passed their test.

Q What does the field of internal medicine involve?

A The best analogy is that, what pediatrics are to children, internal medicine is to an adult. The major issue for an internist is the care of adult patients; and really encompasses the whole spectrum of care other than that which is specifically surgical.

The typical kinds of diseases that an internist will take care of will include things like diabetes and hypertension. Internists traditionally take care of patients who have those kinds of diseases when they're

hospitalized, as well as in an outpatient setting.

Internal medicine is also the basis from which other specialties are derived. For instance, if you're going to be a cardiologist, you have to have been an internal medicine specialist first before they'll let you become a cardiologist. If you're going to be a gastroenterologist, you have to have done internal medicine first.

Internal medicine physicians typically receive referrals from a variety of other physicians of complicated adult cases, traditionally those that don't usually require surgery, or where a question as to whether or not the patient ought to go to surgery has been raised. I guess, in essence, that's what constitutes internal medicine.

There are many different branches of internal medicine. I chose the critical care branch early in my career, and now, because of the responsibilities I have as full-time corporate medical director, I find it's much

easier to schedule time in the emergency room at Wishard than it is to schedule time in the I.C.U., because, in the emergency room, you can -- when you're done, you pass the patients that you haven't quite finished with to the next emergency room attending that comes along, and the I.C.U. it's more difficult to do that because of the continuity of care that's involved because the patient is there for such a long period of time.

Q Can you tell us what's involved generally in the area of medical management in which you're also board certified?

A Medical management is a relatively new field for physicians. It's been over the past decade or so that there's been an explosion of interest in health care cost containment and reforming the health care system.

Those physicians that have been involved in management of clinical operations or in management of government programs, or in management of combinations elected a few years ago to put together the requirements for making

a board to certify in that discipline.

And typically the people that are certified in medical management are folks that run large -- physicians who run large hospitals, who run large clinics, who are involved in major insurance enterprises, who are working for the public health service, who are state health commissioners. Those are the kinds of folks typically who -- or managing budgets that are designed to affect the health of patients.

Q In your profession in addition to the positions which you have explained, have you received any appointments relevant to your area of -- areas of expertise?

A When you say appointments, do you mean to certain committees and so on?

Q Yes, sir. Yes, I have. I've had numerous opportunities to participate in a variety of committees related to various aspects of health.

I was appointed to President Reagan's AIDS Commission back in the mid-'80s. I became vice

chairman of that commission; unfortunately, I had to resign from that position, along with the chairman, because of the specific interests of the White House that we felt weren't conducive to moving forward in AIDS.

I've been on a variety of other policy-making bodies and commissions throughout my career. Been on a number of boards of directors.

I'm on the board of directors today of the Association for Health Services Research, which is the major association in the United States that oversees many of the research policies and activities of universities who are interested in health care, schools of public health that are interested in health care.

I'm on the board of a number of corporations. I've been on the board of a number of corporations.

Today I'm on the board of Acordia of Central Indiana, of Allmed Corporation. I've been on the board of trustees of Stanford University for five years. I'm currently on

the board of directors for Stanford Health Systems, which is an entity that was spun off by the board of trustees to manage Stanford's hospitals, Stanford's Faculty Practice Plan, and to oversee Stanford strategy for health care reform in the California -- San Francisco Bay area where they've got a very high percentage of managed care, things are not quite as settled as they are today here in Indianapolis, in Indiana, from a health care standpoint. So those are the kinds of things I've been involved in and continue to be involved in.

Q Where, Doctor, are you licensed to practice medicine?

A I'm currently licensed to practice in the state of Indiana, state of California, state of New York, and in the District of Columbia.

Q Have you had clinical experience in treating people who were suffering from diseases associated with cigarette smoking?

A Yes.

Q Can you tell us what experience you've had in

that regard?

A Virtually all the settings where I've been involved as a resident or as a faculty member or as an attending physician, I've had occasion to see patients who smoke cigarettes and who have developed one or another of the complications of their nicotine addiction.

I have seen patients with illnesses that are fairly common from their cigarette smoking. I've seen patients with illnesses that are less common. I see patients every time I'm at Wishard who got one complication or another of their nicotine addiction, including bronchitis, which is a very prominent one this time of year that can lead to pneumonia, and as serious as cancer and heart disease.

Q Have you had occasion to be involved in the diagnosis and treatment of individuals who have lung cancer?

A Yes.

Q Can you give us some idea of the frequency with which you've become involved in the treatment of individuals with lung cancer over the course

of your professional career?

A Lung cancer is a disease that requires a lot of effort on the part of the physician and nurse team. It can require a variety of different forms of therapy from surgery to radiation to chemotherapy. And as a result of those therapies and as a result of the disease itself, there can be a number of complications of care, so you see those patients quite frequently, unfortunately, in both the emergency room and in the clinic setting. I've had a number of patients who I've seen in both settings who have lung cancer and/or some of the complications associated with it. I've seen patients in the I.C.U. with the same problems.

I don't think there's any part of my career, clinically or otherwise, that I have not seen patients with complications of cancer of the lung as a result of their nicotine addiction.

Q In accordance with your training and your actual work in the field of public health, have

you had an opportunity to deal with the relationship between cigarette smoking and health hazards?

A Yes.

Q Can you tell us your experiences in that regard?

MR. WAGNER: Just a moment. I'm going to object to this line of questioning, your Honor, because I think that this witness is going to testify now to matters that are wholly foreign to any issues in this case, namely, some relationship between public health, as the question has posed to this witness, and smoking. That's not an issue in this case. This is not an opportunity for the plaintiffs in this case to inject things that will be prejudicial to the defense.

MR. HARDY: Your Honor, I'd like to add that it is clearly beyond the scope of the 26(b) designation which is restricted to lung cancer specifically.

THE COURT: Could you provide me, I don't know -- some of the witnesses through

the course of discovery, those 26(b)s got in the file, most of them are not, so when you -- I'm limited to -- you've read them to me once and I'm limited to try to remember what it was. But if I could just see, please, a copy.

MR. HARDY: May I approach the bench?

THE COURT: Sure, yes, please, please.

MR. HARDY: Pages 11 and 12.

THE COURT: Let me ask counsel to approach the bench, please.

(The following bench conference was held outside of the hearing of the jurors.)

THE COURT: Help me understand where -- the question is, if you can see, "Have you had the opportunity to deal with the relationship with cigarette smoking and health hazards."

MR. MICHAEL HOLLAND: I can withdraw it and make it specific to lung cancer, that's fine.

THE COURT: Is that what you'll

do?

MR. MICHAEL HOLLAND: That's what I will do.

MR. WAGNER: It is still objectionable because what he's doing is attempting to inject an issue in this case that has to do with the relationship with either the public health, which is on your Honor's screen, and smoking or health hazards of smoking and that sort of thing, get him to talk about that, and that is totally improper and that's going to be very prejudicial to the defendants in this case.

I mean, it's clear that this is where this line of testimony is going. And that question is objectionable and any question like that question is going to be objectionable, whether it's tied to lung cancer causation or addiction, and if it's tied into public health concerns and that sort of thing, that's not an issue in this case.

This is, first of all, a consumer expectation state, has nothing at all to do

with this witness's views about smoking and public health. Besides that, it's clearly outside his 26(b) disclosure, he never testified about this.

THE COURT: Well, are you going to talk about the issue of lung cancer? And so what you're saying, you're going to withdraw this question and ask him one more about lung cancer.

MR. MICHAEL HOLLAND: The relationship between cigarette smoking and lung cancer.

THE COURT: As a causal connection between smoking?

MR. MICHAEL HOLLAND: Right.

THE COURT: Okay. Now, the issue about public health, and it's a little blurry sometimes because perhaps I haven't dealt with that issue, and it's sort of the finite detail here. But it seems to me if we're talking about causation, it is an appropriate area. And your concern is -- I just want to make sure I understand your concern, the concern about

public health issues -- what kind of questions, what kind of information would be prejudicial are you talking about?

MR. WAGNER: It's precisely this, Judge: This witness, as you've already heard, has spent most of his career in some sort of a public job, New York, Indiana health commissioner, so forth and so on. He is now administrator of health claims at Associated Group.

What I anticipate this question and other questions are going to lead to is his opinions about how smoking impacts public health matters, impacts insurance claims, impacts the role of people that administer public health and matters of that kind. That's what that question is posited upon and it's clearly, one, not an issue in this case; to talk about it is, secondly, highly prejudicial to the defendants in this case; and thirdly, it is clearly outside his 26(b) disclosure.

THE COURT: I think it is talked about but it isn't posited in those terms, the

harmful effect of cigarette smoking that 400,000 deaths a year, those are public health statements. And I guess what you are saying is that the context and how the questions and how the issue is inserted in the trial is much different.

It seems to me that when you say that -- other witnesses have testified that 400,000 people die every year as a result of smoking and tobacco products, that's a public health statement, but you're saying, and I guess that's what I am trying to distinguish, we have a lot of public health -- a lot of testimony that obviously impacts upon the public health in terms -- and I guess partly in dealing with the harmful effects of smoking, but it's tougher for me to see, I guess it's -- are you saying it's the context in which it's raised?

MR. WAGNER: Absolutely.

THE COURT: Okay.

MR. WAGNER: Absolutely. I mean, and --

THE COURT: I think I understand,

but I don't know whether I have a tremendously firm grip on exactly what the position is, but I think I see what you said to me just now. I think what's going to happen, what you suggested is to withdraw the question concerning the issue of causal connection between --

MR. MICHAEL HOLLAND: Between lung cancer and cigarette smoking.

THE COURT: Let's try it from there.

Dave, if there's a time maybe at the next break if I could --

MR. HARDY: Get you a full copy.

THE COURT: Yes, it would be helpful and less awkward.

(Conclusion of bench conference.)

MR. MICHAEL HOLLAND: We'll withdraw the question and ask another question.

QUESTIONS BY MR. MICHAEL W. HOLLAND (Resumed):

Q Doctor, in the course of your training and your position -- positions in the field of public health, have you had an opportunity to consider

the relationship between cigarette smoking and lung cancer?

A Yes.

Q Can you tell us your experiences in that regard?

A Well, of course, in public health and in medicine, it is very clear that the patients who have lung cancer are patients who have a huge problem with their cigarette smoking, nicotine addiction.

From a public health standpoint, it serves as the basis for all the programs that we put in place --

MR. WAGNER: Your Honor, I don't mean to interrupt the witness, and I apologize for doing that. But we just had this discussion at your Honor's bench about the objectionable nature of this testimony.

And, secondly, there is no foundation laid at all for this witness to testify as to any of these matters. All he's described is his positions holding government jobs and things of that sort. This witness hasn't presented any

expertise in any area about the subjects that he's now narrating about in answer to Mr. Holland's questions.

THE COURT: Yes, and I think he's responded to the question within the area that we talked about. I'll sustain the objection. Next question, please.

Q Doctor, as a professor of medicine, have you had occasion to teach with respect to the relationship between cigarette smoking and health risks?

A Yes.

Q Do you have, Doctor, experience in the field of epidemiology?

A Yes.

Q And what is epidemiology?

A Epidemiology is the science that allows those involved in it to look for relationships between variables within a population and disease, correlation with those variables in certain types of disease, such as correlations of cigarette smoking with cancer and heart disease as an example.

Q In your field and positions in the field of public health, have you had occasion to apply principles of epidemiology to health issues?

A Yes.

Q Have you had occasion to apply your knowledge and expertise in the area of epidemiology to questions of cigarette smoking and health hazards?

A Yes.

Q Can you tell us from that standpoint whether, in your opinion, there is a relationship between cigarette smoking and lung cancer?

A There is a strong relationship between cigarette smoking and lung cancer.

Q On the basis of your education, training and experience, Doctor, do you have an opinion as to whether cigarette smoking is a cause of lung cancer?

A Yes, I do.

Q What is that opinion?

MR. WAGNER: Just a minute. I'm going to object to that, your Honor, for the reason that it is one thing for the witness to

talk about associations and another thing for the witness to talk about a cause, there has been no foundation laid for this witness to express an opinion with respect to that particular question.

THE COURT: The foundation has been laid, I think, a wide breadth of experience for this witness. I am concerned about the basis, also, whether it's sufficient to support this particular opinion. And I just don't think the record supports it, at least at this stage in the record. I'll sustain the objection.

Q Doctor, in your education, training and experience, what factors do you consider in determining whether there is a causal connection between cigarette smoking and lung cancer?

A Well, there are a number of factors that one has to look at in order to -- to make such a judgment. Of course, you're relying upon the medical literature, you're relying upon the role and opinions of your colleagues, you're

relying upon your own clinical experience in seeing patients.

I think that in looking at such relationships, you want to look at the data with respect to the strength of the association, the time interval between the cause and the effect that you're looking at. You want to look at whether the association is very specific or not specific. You want to look at whether or not the different aspects stick together, whether they're coherent as you ponder -- as you move through the evidence.

I guess what you do is synthesize all those various aspects together and you come up with a decision in your own mind as to whether there is a cause. It is a clinical judgment in many cases. And my clinical judgment is very clear in this case that cigarette smoking is a cause of lung cancer.

Q Doctor, what has been your clinical experience with respect to the occurrence of primary lung cancer in individuals who do not smoke?

A I've seen a number of patients with lung

cancer, primary lung cancer, and I have never seen a patient with primary lung cancer who did not have a significant smoking history.

Q Doctor, is your opinion concerning the relationship between cigarette smoking as a cause of lung cancer consistent in your opinion with the consensus of the medical and scientific community?

A Oh, yes.

Q In your opinion, is there any authoritative, reliable or respected opinion to the contrary?

A There is not.

Q Doctor, have you had experience in becoming involved in the treatment of individuals who are trying to stop smoking?

A Yes.

Q Can you tell us about your experiences there?

A Ever since medical school and you start seeing patients in the clinic, you're taught to focus not just on the disease or diseases that the smoking causes, but you're also taught to do what you can to intercede such that that doesn't get worse.

And in all the teaching that I do today, that's the major principle, not just to go after the bronchitis or cancer or whatever you're worried about, but to try to stop the cause.

It's very, very difficult for many patients to stop their smoking. The data that I am aware of suggests that over a third of people who smoke cigarettes every year try to stop and can't do it because of the nicotine addiction.

There are many different theories on the best way to stop smoking. Some people believe that you augment the nicotine addiction from cigarettes with something like a nicotine gum or patches and then you decrease their use over time.

Other experts believe that the best way to do it is in an educational classroom type setting.

Some people believe that hypnosis works. In some cases it clearly has had a positive effect.

Others of us suspect that the best way to do it is to stop what some people refer to as cold turkey, just to have the patient set a date and a time for their last cigarette and have that and then never have another one again.

My advice to patients, as we review all their options, is to pick one of them and do it. It doesn't really matter as the physician which one they choose as long as they choose one and they can be successful.

I've had particular luck when you focus on the Great American Smoke-out Days that have been sponsored I think by American Lung Association where everybody is supposed to take a day off from smoking and then see if they can keep that going. Sometimes there's a lot of peer pressure in the workplace, people encouraging somebody to do it. I think they get support, positive support and reinforcement so that they take advantage of that.

The fact is is that this drug nicotine is very, very difficult for patients to control.

And a large number of patients can't, and find it exceptionally hard to do so. All the methods that I have talked about have some usefulness for some patients at some point in their life and hopefully they can find one that works for them.

The point is, as a physician, you keep encouraging them to try. If one doesn't work, you try another one, and you keep pushing them to not give up on the idea of quitting, because sooner or later one of the methods that they choose can and will work for them. At least that's what you want them to believe, and believing that is the case, is I think an important adjunct to stopping their addiction.

Q Doctor, on the basis of your education, training and experience, do you have an opinion which you can state to a reasonable degree of medical certainty whether nicotine and cigarette smoking -- cigarette smoke is addicting?

A Yes.

Q What is your opinion?

A I believe very strongly that it is addicting.
Q What is it about the cigarette that is addictive?
A What a lot of us believe is that the cigarette is really a drug delivery system for nicotine. The nicotine is packaged in a cigarette. By lighting the cigarette with your fire, and by inhaling, the design is such that you get that nicotine into your mouth and into your trachea and then into your lungs, where it's absorbed into the bloodstream. And studies have shown clearly that it's absorbed fairly rapidly. Within a minute to three minutes people get a rise in their blood nicotine levels from inhaling cigarette smoke.

That nicotine then has a number of physiologic effects on the patient. First of all, it affects the chemical receptors in the brain. Studies have shown that the EEGs, electroencephalographs, of patients can be altered as a result of nicotine. It increases the heart rate. It increases the amount of blood flow centrally and decreases the blood

flow peripherally, and one of the ways you measure that is looking at skin temperature. Skin temperature can go down when you're smoking cigarettes. Your heart pounds a little harder. Some patients use that sensation and interpret it as being more alert.

Nicotine has been shown to increase the blood sugar, making more sugar available to the cells in the body, so that people get sometimes a sensation of more energy when they smoke as well.

All these physiologic effects are positive reinforcement for having smoked the cigarette. And what happens is that the patient smokes, gets those positive reinforcement, physiologic kind of steps, cigarette goes away, the nicotine level goes down, the reinforcement goes down, the patient wants it again. So the patient lights up the next cigarette.

It's not the first cigarette that you smoke that addicts you, it's the second, third, fourth and fifth and so on that addicts you. And for a lot of patients, once they get in

that cycle, that's it, especially for teenagers, which is where most patients who get addicted to cigarettes and to nicotine, that's the time period where that addiction starts.

That is why it's so important for programs to be in place to keep teenagers from ever starting, because if you can get somebody past the age of 19 or 20 without ever having touched a cigarette, you've got a really good chance that, as an adult, they won't. But it's that peer pressure, it's that wanting to be like the older kids, or wanting to be like dad or mom or whatever that teenagers go through that make them especially vulnerable to habits like starting to light up and then the addiction that results.

I don't know if I've answered your question or not, Counselor, but that's my opinion as to what happens.

Q Yes, thank you, you have.

Doctor, in your clinical experience, have you had occasion to see patients who have been diagnosed with cancer, yet continue to smoke?

A Oh, yes. Absolutely.
Q Could you tell us your experiences in that respect?
A Oh, there have been many patients, they'll come in, and some patients, especially with head and neck cancer, they can't use their mouths any more to swallow because the cancer has eaten away parts of their esophagus or pushing in on their trachea, and they'll have sometimes a tracheostomy, which is an insertion in the trachea, where they have a little tube in helping them to breathe. I have seen patients on many occasions put the cigarette into the trachea, into the tracheostomy, and inhale to get the nicotine. It's just absolutely amazing that patients would do that.

I've seen patients who are on their -- who wouldn't come to the hospital for their chemotherapy because the hospitals a few years ago started making the wards nonsmoking. So they would choose to not get their chemotherapy, or you had to fight with them, and their family would help you, to get them to

come in to get their chemo by convincing them, look, you don't need to smoke during the period of time you get your chemotherapy in the hospital, because the hospitals, of course, almost all of them went nonsmoking.

You'll see patients that are coming in for bronchitis or pneumonia; in fact, I saw a patient last Friday who had bad bronchitis, also had some coronary artery disease, and a lot of times because you get close to people when you're examining them, you can smell the cigarette smoke, the tobacco on them. I looked at him, he had this big pack of cigarettes in his pocket, I was with one of the interns and, of course, we wanted to make a big deal out of it. We pulled them out of his pocket, asked what would he rather have, the Kools or the prescription for the bronchitis? Because they couldn't work both together. And fortunately, in that case, he allowed us to throw them in the trash and we hopefully convinced him that was the last time he ever should smoke a pack of Kool cigarettes.

So, no, it is very clear that this addiction is incredibly tough for people to stop. Even when they know they are dying of lung cancer and other diseases, the addiction is so powerful that they continue, many of them, to smoke. That's why this is such a terrible problem for us in medicine.

Q Doctor, in your opinion, is there a consensus in the medical and scientific community with respect to whether cigarette smoking is addictive?

A Oh, yes, it's addictive.

MR. MICHAEL HOLLAND: Thank you, Doctor.

THE COURT: Cross exam?

MR. WAGNER: Yes, thank you, your Honor.

CROSS-EXAMINATION,

QUESTIONS BY MR. RICHARD D. WAGNER:

Q Dr. Myers, my name is Richard Wagner. I'm one of the attorneys in this case for the R.J. Reynolds Tobacco Company.

Dr. Myers, it's correct, isn't it, that

most of your career has been spent in activities other than the clinical practice of medicine; would that be a fair statement, Doctor?

A I would not characterize my career that way, Counselor.

Q Would you say more than 50 percent of your career has involved you with things other than the clinical practice of medicine?

A I guess it would depend on how one defines clinical practice of medicine. In my activities that are not directly with an individual patient, I would still consider those, many of them, clinical because they relate to the disease processes of those patients.

If your question specifically is whether or not more than 50 percent of my career is spent at the bedside in the I.C.U. or in the clinic or emergency room with a patient, it is not.

Q Doctor, you were deposed in this case, were you not, on October the 4th, 1994, a little over

three months ago?

A Yes.

Q At the time of your deposition, of course, you were sworn to testify to the truth under oath; is that correct?

A Yes.

Q Let me ask you, sir, if you recall being asked this question and giving this answer on page 66 of your deposition: "Would you agree with me that reviewing your career as a whole to this point, you have devoted the majority of your time to public service, teaching health care management and other activities as opposed to actually the clinical practice of medicine?"

And you answered that, "By majority, you mean greater that 50 percent over the course of 14 years, the answer is yes."

A Depending on the definition of clinical medicine that you would choose in the context of that.

Q Isn't that the same question I just asked you, Doctor?

A Depending upon the clinical definition that you

would choose, that question could be interpreted as the same.

Q Doesn't the clinical practice of medicine mean seeing patients?

A Not necessarily.

Q Not to you. Is it true, Doctor, that you never had your own private medical practice?

A Depends on how you want to define private medical practice, Counselor. If you mean by that where I have been in the solo practice of medicine as a full-time occupation, the answer is no. If you mean have I had private patients that came to see me and there was reimbursement made to the hospital or to the environment in which I was practicing, the answer is yes.

Q You've never, as lawyers say, hung out your shingle and had an office with employees and people in the private practice of medicine come to see you as they would a family --

A I've have a shingle out, Doctor -- or Counselor, where --

Q Pardon me?

A I have a shingle out, if the shingle means the

name on the door, but I have never been in a situation where that was the primary business that I was engaged in exclusively.

Q In fact, you never at any time in your career have been engaged full time exclusively in treating patients; isn't that correct?

A That is correct.

Q Now, as I understand it, Doctor, you graduated from medical school in about 1977?

A June of '77 is correct.

Q And that would have been about 18 years ago; is that correct?

A Yes.

Q During the last four years of those 18 years, as I understand it, you've been, since 1991 to the present time, with The Associated Group?

A That's true.

Q Is that correct?

A That is correct.

Q In fact, your office is on Monument Circle?

A Yes, it is.

Q And The Associated Group sells medical insurance?

A Some of the subsidiaries in The Associated Group offer medical insurance, yes.

Q As I understand it, part of your job there is to oversee medical insurance claims?

A Not at the present time, Counselor.

Q Was that true when your deposition was taken, Doctor --

A Well --

Q -- three months ago?

A It depends upon what you mean by oversee, Counselor. If you want to define oversee as being the actual looking at of individual claims and managing the decision-making process for those claims, I no longer manage that on a full-time basis. That's managed by others.

I have a role to play as needed, but since the creation of the newest subsidiary of The Associated Group, Athena of North America, which had its debut in January, I've done much less oversight and much more with medical information and clinical systems.

Q Did you have responsibilities at The Associated Group in October of 1994 when your deposition

was taken for the oversight of medical insurance claims?

A I had some responsibilities along those lines, yes, sir.

Q All right, sir. And that's what you testified to in your deposition a little over three months ago, right?

A Yes.

Q Now, well, from approximately the last four years you've been at The Associated Group, and I believe you've testified that you also put in some time at the Wishard Hospital here in Indianapolis; is that right?

A Yes.

Q And you do that about twice a month, right?

A Two to three times a month, yes.

Q I think you testified in your deposition on the average about twice a month; is that correct?

A Yes.

Q And the twice a month that you're at the emergency room in Wishard Hospital represents a stint that you do from about 5 p.m. to 11:30 p.m., right?

A That's correct.
Q Which is about six and a half hours?
A That's about right.
Q And Wishard Hospital's emergency room treats a lot of trauma patients?
A It does.
Q People who are involved in car accidents, gunshot wounds and that sort of thing?
A Yes, it does.
Q And then another two of these approximately 18 years since you've got out of medical school, I believe, were spent as the Commissioner of Health in New York City; is that right?
A That's correct.
Q And that was a full-time job?
A Yes, it was.
Q From 1990 to 1991?
A Yes.
Q And at that time and during those years, you were not actively involved in the practice of medicine, right?
A Not actively, no, sir.
Q And then for five or six of these 18 years

since you've been out of medical school, you were the Health Commissioner of the State of Indiana; isn't that right?

A Yes.

Q That was from 1985 to 1990?

A Yes.

Q That was also a full-time job?

A Yes.

Q And for a few months in the last part of 1984, you were an adviser to a United States Senate committee in Washington, D.C.?

A Yes.

Q And you described your experience at the San Francisco General Hospital, and that occurred in 1982 to 1984, approximately; would that be correct?

A Yes.

Q And actually, when you were at the San Francisco General Hospital, you worked in I.C.U. or the intensive care unit; is that correct?

A That was one of the places I worked, yes.

Q And you saw in the I.C.U. or intensive care

unit surgical or trauma-related patients?

A We saw a huge variety of patients. It was the medical/surgical I.C.U., so we saw both patients that had complications of medical illness and those patients that had some kind of problem with surgical illness.

Q And a large part of your time in that job from 1982 to 1984, you were responsible for administrative matters, right?

A About 50 percent of my responsibility was administrative, 50 percent was clinical during that two and a half years.

Q All right. And then about two more of those 18 years since you've graduated from medical school, you were in the Stanford School of Graduate Business; isn't that correct?

A Yes, I was.

Q You pursued a master's degree in business administration there?

A Uh-huh -- yes.

Q In fact, that would have started about three years after you graduated from medical school, right?

A A little over three years. However, I was very clinically active during that period of time, Counselor.
Q Well, I think you described the clinically active activities, as you just put it, as sidelights to your pursuit of a business degree from the Stanford Business School; isn't that correct?
A It's exactly the opposite, Counselor. The business school was a sidelight to my interest in clinical medicine. In fact, I went to business school because I wanted to augment what we were able to do at the bedside.

Unfortunately, treating patients one at a time in the I.C.U. or in the clinic, for me, did not represent what I thought would be the maximum contribution I could make, so I wanted to find other ways to treat more patients than just the one that was at the bedside, and the business school experience and health policy experience allowed me to be able to do that. So I saw it in the opposite way that you described it.

Q Well, it's a fact, isn't it, Doctor, that the setting in which you provided any medical care to patients in the last several years has predominantly been in the emergency room in hospitals; is that a correct statement?

A In the last several years, yes, that's correct. But, Counselor, you, I'm sure, realize that over 80 percent of the patients that come to the emergency room are not true medical emergencies --

Q Now, you're aware --

A And they are, in fact, patients that have --

Q Excuse me, Doctor, you answered the question.

A I thought that you asked me to answer the question. I was trying to answer it for you.

Q Doctor, is it correct, then, that you're a former smoker?

A Yes, it is.

Q And you smoked when you were in college?

A Yes.

Q And I believe you stopped smoking while you were in medical school; correct?

A That is correct.

Q And you stopped smoking while you were in medical school because of health reasons, your concerns about the health consequences of smoking?

A Yes.

Q And then again when you were in your internship and your residency, you smoked?

A Very little, but yes, I did.

Q The reason that you smoked when you were in your internship and your residency was because there would be long periods of time when you would go without rest and you smoked in order to keep awake and alert?

A I, unfortunately, chose to drink a lot of coffee and smoke cigarettes during those nights when I had to stay up, yes.

Q And, again, you stopped when you finished your residency because of your concern about the health consequences of smoking; correct?

A That is correct.

Q And then you took up smoking again in 1985; correct?

A That is correct.

Q And you took it up at that time because you were on a diet?
A That is correct.
Q And you had a fairly severe diminution of your caloric intake?
A That's correct.
Q You smoked because smoking took your mind off of the diet.
A No, that's not correct.
Q Well, Doctor, didn't you testify to that in your deposition?
A I don't remember the exact words. I would choose another way to describe it, however. I may have said those words if that's what's in the transcript. I don't deny it, but the --
Q All right, sir. I believe you smoked, then, from 1985 to 1988 when after the time that you took up smoking because of the diet; right?
A I would average a couple cigarettes a week, yes.
Q All right. And in fact, that smoking episode in your life, Doctor, was when you were the Health Commissioner of the State of Indiana; is

that right?

A That is correct.

Q And then when you went to New York you were still smoking and you finally quit entirely in 1992; right?

A That is correct.

Q And all of these quits that you experienced, you did all those on your own without any help from anybody or any kind of assistance; is that correct?

A Yes.

Q Now, Doctor, it's a fact, isn't it -- I want to ask you some questions about some of the opinions that you have expressed here this morning. It's a fact, isn't it, Doctor, that you've only, I think as you've put it, skimmed the 1964 Surgeon General's Report?

A I've read the report.

Q Didn't you describe it as having skimmed the report in your deposition?

A I may have chosen those words in the deposition, yes.

Q Was that, when you told us that in your

deposition, was that accurate, that you had only skimmed it?

A That's accurate, I had skimmed it right before I had came into the deposition.

Q Doctor --

A I had also believe at the deposition suggested to you that I had read it prior to that point of time as health commissioner, and I have read it subsequent to that point of time.

Q You've read it since October of 1994?

A Oh, yeah.

Q Did you read that because someone told you to?

A I read it in order to optimize my preparation for being here with you, Counselor.

Q We thank you for that. It's a fact, isn't it, Doctor, that you have never read the entire 1988 Surgeon General's Report.

A '88 or '64?

Q 1988.

A I have looked through the entire report, yes, Counselor.

Q Have you read it?

A If you asked me did I read every word, probably

not, but I've touched every page and looked at every page.

Q Doctor, it's a fact, isn't it, that you do not know what the criteria were that the 1964 Surgeon General's Report used to define addiction?

A The 1964 Surgeon General's Report, in my opinion, did not adequately define addiction with respect to nicotine. They corrected that, of course, later on. In fact, the World Health Organization corrected that later that year, if I remember correctly.

Q Doctor, I apologize to you. I probably didn't ask a very clear question. My question, Doctor, was: It's a fact, isn't it, that you do not know what the criteria were that the 1964 Surgeon General's Report used to define addiction.

A I believe I could talk about addiction as it was represented in the '64 --

Q Are you telling us here today that you know how the 1964 Surgeon General's Report defined addiction?

A The Surgeon General's Report in '64 made a distinction, Counselor, between addiction and habituation. And they thought of drugs, such as the opiates, as being addicting, where they looked at tobacco and nicotine as being habituation or habit-forming drugs.

The distinction that they made was primarily based upon whether or not there was some overall effect to society, and they felt at that time that -- or at least in that report, that the addicting drugs had an effect on society where the habituating drugs did not.

Clearly, that was, in my opinion, a semantic distinction that shouldn't have been made. In fact, as I suggested earlier, it was corrected. Is that what you are asking me about, Counselor?

Q I thought I asked you the question as to whether or not you knew what the criteria were that were used in the 1964 Surgeon General's Report to define addiction.

A I think I just answered you.

Q Do you know what those criteria were?

A I just answered you. The addiction criteria were based upon whether or not the product in question, in addition to the physiologic effects that it had on the patient, had an overall effect on society.

Q Doctor, it's accurate that you didn't know the answer to that question in October of 1994 when you were asked at your deposition.

A I can't specify what I said at the deposition.

Q Well --

A If you want to read it to me.

Q Perhaps I can remind you.

You were asked this question and you gave this answer at page 130: "Do you know what the criteria were that the 1964 report used to define an addiction? Answer: I can't recall it specifically, no."

Was that a truthful answer that you gave at that time, Doctor?

A I think, however -- the answer to your question is yes, that was truthful at the time. But if you look in the deposition, we talked a great deal, I remember very specifically, about these

questions in the '64 report.

Q Doctor, it's a fact, isn't it, that you personally have never conducted or contributed to a study on the alleged addictive nature of cigarette smoking?

A That is correct.

Q And you're not a psychiatrist?

A I do not hold myself out to be a psychiatrist.

Q And you don't hold yourself out as an expert in substance abuse treatment, do you?

A I hold myself out as an expert in aspects of substance abuse treatment, yes, but I don't advertise myself in the medical community as someone to refer those kinds of patients to, no.

Q The answer to my question is: You do not hold yourself out as an expert in substance abuse; is that correct?

A To the members of the medical community, that is correct. However, to my patients I am their expert in substance abuse.

Q Would you agree with me, Doctor, that the definition of pharmacology is the science of

dealing with the preparation, uses and especially the effects of drugs? Is that a working definition you and I can agree on?

A When you say drugs, I would assume you mean legal drugs? Yes.

Q Okay. And the term psychopharmacology would be a term that refers to the effects of drugs on our mental state; would you agree with that?

A Yes.

Q And, Doctor, it's true, isn't it, that you have no expertise in psychopharmacology.

A Well, again, Counselor, I don't know whether we're splitting hairs or not, but when you say expertise, I clearly know much more about it than the lay person. There are people in the scientific community that know much more about it than I do. So you'll have to give me a little bit of help on what your definition of expertise happens to be.

Q You were asked this question in your deposition and you gave this answer, Doctor, at page 118: "Do you have any expertise in the field of psychopharmacology? Answer: I am familiar

with issues within psychopharmacology. However, I would not suggest that I have expertise in that particular area."

Do you remember giving that answer to that question?

A Yes.

Q Was that answer true?

A Yes.

Q Is it true today?

A Given the caveat that I just outlined, yes.

Q Now, you've never done any original research on smoking; isn't that correct?

A Yes.

Q It's a fact that you have never done any original research on smoking behavior.

A That is correct.

Q And it's a fact, isn't it, that you're not an expert in determining the psychoactive effects of various drugs.

A That is correct.

Q Would you agree, Doctor, that the Diagnostic and Statistical Manual is an authoritative manual for the diagnosis of psychiatric

disorders?

A It's an authoritative manual for the classification of diagnosis, but the manual doesn't diagnose anybody.

Q Again, maybe my question wasn't quite clear. You agree, do you not, Doctor, that the Diagnostic and Statistical Manual is an authoritative manual for the diagnosis of psychiatric disorders?

A When you say for the diagnosis, Counselor, I'm assuming you mean for those individuals who have expertise in diagnosis as a reference book. If that is what you mean, the answer is yes.

Q All right, sir. And you have never read the section on nicotine dependence in the Diagnostic and Statistical Manual III-R, have you?

A No.

Q And, in fact, I believe you testified at your deposition you had only skimmed the section on nicotine dependence in DSM-IV; right?

A Correct.

Q As a matter of fact, you received an excerpt of that particular version of the DSM from plaintiff's counsel; is that correct?

A That's correct.

Q Doctor, the word or term psychoactive has sometimes been used, maybe during your testimony, I can't quite remember actually. But that term, you agree with me, means something that has a significant effect on our mental state.

A That's a fair definition.

Q And, Doctor, it's a fact, isn't it, that many common experiences and activities produce some of the same physiological and psychoactive effects that are produced by smoking a cigarette?

A I believe there's a distinction that I would make, Counselor, depending upon the physiologic effects of whatever it is that you're using as an example. All psychoactive effects are chemically mediated. There is no effect that I can think of that is not in some way mediated by receptors in the brain and their stimulus or

their deactivation in some way. If whatever you have in mind follows that same pattern, then perhaps you are correct.

Q Did you say perhaps I am correct?

A Depends on that example that you might want to give.

Q Well, some examples would be excitement, exercise, and sex; isn't that correct?

A Because those -- exercise and sex have been shown to increase endorphin release in the brain. There are receptors that, when the endorphin attaches, are activated and those activated receptors cause the individual to feel what is interpreted as a pleasurable sensation; correct.

Q So the answer to the question I originally asked you would be yes; right?

A With respect to exercise and sex, yes.

Q Those are common experiences, are they not? Or at least some of us hope so.

A We would hope so, yes.

Q And, in fact, Doctor, caffeine can produce psychoactive effects; isn't that correct?

A Caffeine can produce psychoactive effects, yes.
Q And, in fact, caffeine can produce a stimulated state which is one reason people enjoy caffeine; isn't that correct?
A It's one reason why people use caffeine. Enjoy is a different word.
Q In fact, Doctor --I'm sorry, did I interrupt your answer? I apologize.
A Caffeine use is, I think, an area where the word enjoy, I think in many respects, doesn't apply to the actual caffeine but applies to the taste of the tea or the cola or the coffee or whatever it is that's producing the caffeine. I'm not sure that you can say people that take caffeine pills in order to stay up at night, that they enjoy it. But it does produce psychoactive effects.
Q Well, you were asked this question, Doctor, at page 163 of your deposition: "Would you describe the pharmacological and psychoactive effects of caffeine." You answered: "The caffeine in many patients and the other methylxanthines" -- am I producing that

correctly?

A Xanthines.

Q All right. -- "tend to produce a stimulated state which is partially the reason people enjoy using those." Wasn't that your words?

A Yes, and emphasis on the word partially. And I was explaining the other side of that in my answer with respect to taste, Counselor.

Q But people at least partially enjoy that stimulated state; right?

A Yes.

Q In fact, Doctor, in your opinion, coffee can produce the same feelings of heightened awareness that people may experience when using tobacco?

A It's a similar feeling in some patients, yes.

Q And it's your opinion, isn't it, Doctor, that caffeine has addictive characteristics?

A No, that's not how I would characterize it. I would suggest to you that caffeine certainly has physiologic responses, but that those responses are not in the same category as addiction than -- compared to tobacco or to

opium or to any other substance.

A lot of the patients, for instance, Counselor, can use decaf teas or decaf coffee or decaf cola and gain satisfaction from it. I don't know of anybody that uses a denicotized cigarette. In fact, they need the nicotine in order to get the effects of the enjoyment. So I wouldn't characterize it as the same.

Q Doctor, do you recall giving this answer to a question about caffeine at page 166 of your deposition? You said, "I don't think it, caffeine -- let me rephrase. Caffeine has addictive characteristics." Do you remember saying that?

A There are some characteristics that have -- that are similar, but it is not the same as nicotine, no.

Q Well, Doctor, I didn't ask you about whether or not it is the same as nicotine. I asked you whether or not in your opinion it had addictive characteristics and the answer to that question is, in your opinion, yes; right?

A There are some characteristics that are

similar, yes.

Q And you said in relationship to caffeine at page 166, "It's addictive in the sense that many patients use it, use it regularly with difficulty in controlling their use of it."

Do you remember making that statement?

A Yes.

MR. MICHAEL HOLLAND: Excuse me, I'm going to object that he's quoting from the deposition, but the doctor does not have the deposition before him, and he's taking pieces of testimony that are part of a complete answer. So that's my objection. I don't think there's a proper foundation being laid for cross-examining the doctor from his deposition.

MR. WAGNER: Let me say, first of all, I am laying a proper foundation because the doctor -- I'm asking the doctor a question, he gives me a different answer than his deposition. I've asked him if he made this answer to this question in his deposition. I don't know what further foundation I could lay.

And in response to Mr. Holland's inquiry

about letting the doctor read a copy of the deposition, I have another copy. If he would like to read it himself, he certainly may.

THE COURT: All right, thank you.

Q Doctor, it's your opinion, isn't it, Doctor, talking about the things that you said generally here this morning about addiction, that you don't believe that gambling can be addictive; isn't that correct?

A That's correct.

Q You don't believe that food can be addicting?

A I do not believe that food can be addicting, no.

Q You don't really have any opinion as to whether or not people can be addicted to exercise; isn't that right?

A I think there's interesting research going on in that area that leads me to believe that there may be a chemical tie from the release of endorphins. In fact, some people describe that as the runner's high. People that jog frequently have probably an enhanced sense of themselves that probably is chemically mediated

from endorphin release similar to orgasm in sex, but the research on that isn't complete.

Q Doctor, you do know, do you not, that the 1964 Surgeon General's Report defined cigarette smoking as a habit and not an addiction?

A That is correct.

Q And it's your opinion, isn't it, Doctor, that all regular smokers do not lack voluntary control over their smoking?

A That is correct.

Q It's also your opinion, isn't it, Doctor, that not all regular smokers are addicted to cigarettes or to nicotine?

A That is correct.

Q And it's your opinion, Doctor, that just because someone smokes when they've been advised to quit, that doesn't mean they are, in fact, addicted.

A It is highly consistent with addiction, but it does not invariably mean that they are addicted.

Q Okay. And in fact, Doctor, in your experience in the medical practice, it's common for

patients not to follow their doctor's advice about many matters; isn't that true?

A It's much more common for them not to follow advice about tobacco because of the addictive nature of that substance. It's much more common, although not a hundred percent, that they'll follow advice in other areas like taking their blood pressure medication.

MR. WAGNER: Move to strike the non-responsive answer, your Honor.

THE COURT: I think it was responsive.

MR. WAGNER: The question, your Honor, was it's common for patients not to follow their doctor's advice. I didn't ask the doctor about the subjects that he would like to testify about, I asked him about the subject that I wanted him to testify about.

THE COURT: Well, I think he was drawing a contrast in explaining his answer. I think it's an appropriate response.

While you're taking a deep breath there, let's take a deep breath as well. Let's take a

mid-morning recess. With that, the jury may rise and be in recess about 15 minutes.

(A recess was taken from 10:30 a.m. until 11:02 p.m.)

THE COURT: The jury may be seated. Mr. Wagner, continue, please.

MR. WAGNER: Thank you, your Honor.

CROSS EXAMINATION, (Continuing)

QUESTIONS BY MR. RICHARD D. WAGNER:

Q Dr. Myers, would you agree with me that noncompliance with a doctor's advice is a common phenomenon throughout medicine?

A For some types of advice, yes.

Q And just as an example, with regard to doctors' advice regarding diet and obesity, many patients don't follow their doctor's advice to reduce their caloric intake; would you agree with me?

A That is correct.

Q Many of them don't follow their doctor's advice to engage in exercise programs; isn't that correct?

A That's correct.
Q And many heart patients who have cardiac problems don't follow their doctor's advice to engage in exercise and to restrict their diet, correct?
A Now you're moving over the border here, Counselor. For heart disease patients it's very important that they get very specific advice on exercise and so on, because for some types of heart disease, you don't want the patient exerting himself in an exercise program without a lot of controls placed on it. So, it depends on what type of advice you're talking about.

If it's just general advice to exercise for heart disease patients, that's not advised and they should speak specifically to a physician or whoever she or he refers them to to get better advice.

Q Yes, sir. The only question I was asking really, Dr. Myers, was with respect to heart -- you were talking about people on diets and I was simply asking you, isn't it true with

respect to people who have heart problems, that they sometimes don't follow their doctor's advice to only eat certain kinds of foods or to get more exercise. That's all I'm asking you. Is that a correct statement?

A That's correct.

Q And so it's true, isn't it, Doctor, that the mere fact that an individual smoker continues to smoke in the presence of the knowledge of the health risk associated with his continued smoking, that in and of itself doesn't prove that that smoker is addicted; isn't that correct?

A Addiction is not a phenomena, Counselor, that is advice-dependent. Addiction is a physiologic phenomenon.

Q I'm just asking you whether or not the question that I just asked you is a correct statement.

A Could you repeat the question?

Q Sure. The mere fact that an individual smoker continues to smoke in the presence of the knowledge of the health risk associated with his continued smoking is not itself proof that

the smoker is addicted. You, in fact, agree with that statement, don't you, Doctor?

A That is correct.

Q And, Doctor, it's a fact, isn't it, that many people who stop smoking do so on their own without any specific technique to help them stop?

A Yes.

Q Pardon me?

A Yes.

Q It's a fact, isn't it, Doctor, that smoking doesn't prevent a person from appreciating the risks of smoking?

A Appreciating, yes. Acting on, no.

Q Well, let me reask the question, because I only want to get an answer to my question, Doctor. The question is: It's a fact that smoking does not prevent a person from appreciating the risk of smoking; isn't that a correct statement?

A I guess I don't understand what you mean by appreciating, because my definition of appreciating probably doesn't match up with yours.

What page do you want me to look at?
Q 144, line 5. Let me know, Doctor, when you're there.
A 144, line 5?
Q Yes, sir. Would you like to read the question and answer out loud?
A If by --
Q No, no, you have to read the question first, Doctor.
A "Does smoking rob a person of his or her ability to appreciate the risks associated with it?" Answer: "If by inability to appreciate you mean knowledge of negative effects, the answer is no."
Q We didn't have any problem understanding that question at your deposition, did we, Doctor?
A With the caveat I placed in there, I think I made my point, Counselor. That is that appreciate can be defined in a variety of ways. If you define it as I stated it in the deposition, the answer is no.
Q All right, thank you. I appreciate that. Doctor, smoking doesn't prevent a person from

making a decision to quit smoking either; isn't that correct?

A That is correct.

Q And, Doctor, it's a fact that people who smoke can quit?

A Yes.

Q And it's a fact, isn't it, Doctor, that not all smokers become addicted or dependent upon cigarettes?

A Yes, that is good, thank goodness.

Q In fact, Doctor, I believe it's the case, isn't it, that you never told any patient of yours that you thought, in your opinion, was addicted that they could not control their smoking? You never said that to any patient of yours, have you?

A I have never stated those words to a patient that I can ever recall.

Q You've never told anyone that they could not quit smoking, have you?

A No, I've never told anyone that. In fact, I've told them the exact opposite.

Q In fact, motivation is a very important part of

stopping smoking; isn't that correct?

A It is a very important component, yes.

Q It's a fact, isn't it, Doctor, that in your opinion smoking can be a difficult practice to stop that's long been a matter of common knowledge?

A Yes, that's true, too.

Q It's a fact, isn't it, that according to the Surgeon General's Report, there were in excess of 38 million former smokers in the United States?

A Is that in here?

Q In the 1990 Surgeon General's Report it was reported that there was in excess of 38 million former smokers in the United States?

A I won't dispute that, that's probably correct. It also went on to say that a number of people who had smoked died in the period of time in question as well.

Q It's a fact, isn't it, Doctor, that the 1989 Surgeon General's Report stated that nearly half of all living adults who ever smoked had quit?

A It was maybe half or third, something like that.

Q You do agree, don't you, Doctor, with the statement from the 1988 Surgeon General's Report that approximately 90 percent of former smokers reported quitting without any formal treatment program or smoking cessation devices?

A Of those who quit, yes.

Q Do you agree, Doctor, that most smokers don't require any treatment for nicotine withdrawal when they quit?

A That's correct, if by treatment you mean medical treatment.

Q You agree, Doctor, do you not, that researchers say that for the vast majority of smokers who quit, the effect of nicotine withdrawal is quite mild?

A I wouldn't characterize it as quite mild. It is certainly milder than quitting other drugs, but for some patients it is quite intense.

I --

Q I'm sorry, Doctor, I didn't mean to interrupt. Go ahead.

A In summary I would say that for the majority of people, it is mild.
Q I think that was the question I asked. Doctor, it's true, isn't it, that people who go on a diet and curtail their intake of food may experience the same withdrawal symptoms as someone who stops smoking?
A No.
Q Disagree with that?
A I think that it's a very different phenomenon, Counselor. I think that the major difference I'd point out is that food is something that you need to live, it's not a drug. Nicotine is a drug that you don't need to live. In fact, it kills you ultimately unfortunately. So, I wouldn't equate the two in that way.
Q Doctor, if you'll look at the answer that you gave starting at the bottom of page 181 and over to the top of 182 when you were asked about people who go on a diet and have to severely curtail their intake of food. The question was about whether or not those withdrawal symptoms are comparable to those

that you identified as being associated with the cessation of cigarette smoking. And you said: "No, I didn't say that. I think it's possible that they can experience some symptoms. It is not guaranteed they will experience symptoms. Those symptoms may or may not be similar to the symptoms that some patients will experience when they withdraw."

The question I asked you, Doctor, was: Isn't it true that people who go on a diet and curtail their intake of food may experience the same withdrawal symptoms as someone who stops smoking?

A Counselor, there may be some overlap of starvation with withdrawal, but I don't think that's an example that I would find easy to relate to tobacco withdrawal.

Q Was the answer that you gave in your deposition correct at the time you gave it --

A Excuse me, Counselor, that's a quote from my deposition, page 181.

Q You're quoting from where?

A Page 181, the page that you referred me to.

"There may be some overlap in starvation with withdrawal, but I don't think that's an example that I would find easy to relate to tobacco withdrawal."

Q Yes, sir. Then you were asked a question: "So it's your testimony that a person who is on a diet, say an obese person who has to go on a diet and severely curtail their intake of food, that that person won't experience any withdrawal symptoms that are comparable to what you've identified as the symptoms being associated with the cessation of cigarette smoking."

And you answered: "No, I did not say that. I think it's possible that they can experience some symptoms. It's not guaranteed they will experience symptoms. Those symptoms may or may not be similar to the symptoms that some patients will experience when they withdraw."

A There is not a one-to-one correlation.

Q Yes. So wasn't your answer very fairly, Doctor, that they may experience the same kind

of symptoms as people who withdraw from smoking?

A With the caveats that we have now outlined, yes.

Q Thank you. Now, Doctor, I want to ask you some questions about your testimony here this morning about the association between smoking and lung cancer, some of the questions Mr. Holland asked you about, okay?

Doctor, it's correct, isn't it, that you yourself have never conducted any study on the association between cigarette smoking and lung cancer?

A That is correct.

Q And would you agree with me that the term "pathology" relates to the science of the origin, nature and course of diseases?

A Yes.

Q Is it the fact that aside from a pathology course that you had in medical school, that you had no study or training in pathology or practice in pathology?

A No, that's not correct. In an internal

medicine residency, part of the residency is involved with discipline in pathology, psychiatry, some of the other disciplines that make up the spectrum of diseases that are in adult medicine.

Q So, if I were -- I'm sorry.

A The specific kind of training would be that you have a patient with, let's say, a leukemia and you would go -- you'd perform a bone marrow aspiration and biopsy. Then when the pathologist had finished fixing the slides and staining them, then you would go down to the pathology department and look at the slides with the pathologist and your attending physician in order to determine whether or not the bone marrow did indeed have leukemia and what type it was.

So, that is an example of the kind of pathologic training that you get as a resident. You look at slides of your cancer patients and so on as well.

But the discipline pathology and the residency pathology pretty much does that kind

of thing full time, whereas internal medicine, it's very much just a part of the residency.

Q All right, sir. Well, let's see if I can sort of make through that a little bit. You don't hold yourself out as a pathology expert, do you, sir?

A That's correct.

Q You don't hold yourself out as an expert in radiology either; isn't that correct?

A That is correct.

Q Doctor, it's a fact, isn't it, that, of course, all smokers don't contract lung cancer, right?

A That is correct.

Q Would you agree with me, Doctor, that there's no scientific understanding of the precise mechanism of how lung cancers are caused?

A There is much more understanding of that mechanism today than there's ever been, but if you're asking a question do scientists truly understand every nuance of how the transition from a normal cell to a cancer cell occurs, the answer is no, science is not to that point yet.

Q In fact, science doesn't know why one cell

turns malignant and another cell subject to the same agent does not; isn't that correct?

A Science has ideas on how that occurs, but there is no certainty at this point on the precise mechanism, although we're getting closer.

Q You would agree, Doctor, that radiation causes lung cancer?

A In very high doses, radiation can cause some cells to mutate and become cancerous, yes.

Q And air pollution can be a cause of lung cancer?

A That's a matter of more dispute. I think that most experts would believe that there is some contribution that air pollution makes over long periods of time in highly polluted areas to the overall incidence of cancer, but it is very difficult, I think, for you to attribute air pollution to an individual cancer patient. Although there may be some examples that I am not aware of.

Q Doctor, you, in fact, wrote an article in August of 1985 in Public Health Notes about air pollution and air pollution causing lung

cancer, didn't you?

A I may have suggested that in the article, yes.

MR. WAGNER: May I approach the witness, your Honor?

THE COURT: Yes, you may.

Q I know it's not easy to remember everything. Here is a copy that I believe is an article which you wrote, Doctor. If you want to take a minute to review that, please do.

A Uh-huh. I don't think there's anything inconsistent with what I just said. There's some evidence that air borne toxicants contribute to the increase rate of cancer-related mortality.

Q This article, Doctor, just generally speaking, is about air pollution and its association with lung cancer, correct?

A The article was intended to explain to physicians and others interested in public health how the Clean Air Act that requires regulations for toxic air pollutants affects health and what the goals of the Clean Air Act were with respect to health.

Q See the third column over, Doctor?
A Right.
Q As you and I are looking at it, the first full paragraph. It says: "The level of pollution, age and gender have an impact on cancer mortality rates."
A That's correct.
Q "Heavily industrialized and highly polluted rural areas have much greater cancer mortality rates than rural or less polluted areas," right?
A Right. But that's not limited to air pollution, Counselor. That's water pollution, et cetera.
Q Whether it's water pollution or air pollution, those things can be factors in the cause of lung cancer, right?
A They can be, yes.
Q Would you agree with me, Doctor, that no specific constituent in tobacco smoke has been identified as responsible for causing lung cancer?
A There are thousands of constituents in tobacco

smoke that are believed to be related to lung cancer. The question of any one specifically being identified as the cause is still subject to a lot of research.

Q Okay. And, in fact, there are many things that can cause lung cancer in nonsmokers; isn't that correct?

A Primary lung cancer? The overwhelming majority of primary lung cancer is tobacco-related, Counselor. There are relatively few, in fact, somewhere between only 5 to 15 percent of lung cancers that are primary lung cancers occur in patients that don't smoke. And those are specific cell type, not the type that's related to tobacco. In fact, there are three or four major types related to tobacco and there a couple that aren't. The patients that don't smoke by and large have the type that's not.

Q Perhaps it's the question I asked, Doctor, that wasn't clear. Let me try to reask it again. I'm sorry if I didn't make it clear.

My question was that there are many things that can cause lung cancer in nonsmokers and

whether or not you agreed with that statement.
A Well, what kind of lung cancer are you talking about, Counselor? Are you talking about small cell, anaplastic, large cell, epidermoid or what?
Q I can only ask one question at a time. I just wanted to ask if you agree with that statement.
A I can't answer the question without being more specific or without giving you a better explanation of my answer.
Q Well, Doctor, do you recall being asked that same question at your deposition?
A What page?
Q 357.
A Yeah.
Q Line 11 you were asked: "Do you know the cause of lung cancer in nonsmokers?" You answered: "There can be many causes of lung cancer in nonsmokers." And you said, "Exposure to protected or chemical agents, hereditary factors, metastatic disease are among those," right?
A Right, but that doesn't necessarily apply to

primary lung cancers. It certainly doesn't apply to all the different cell types, but it does apply in general to lung cancer.

Q All right, thank you. And it's your opinion that here in the state of Indiana that radon is a cause of lung cancer?

A Radon can be a contributing factor to the overall cancer mortality rate, although that evidence is clearly in dispute today. The Environmental Protection Agency and others are questioning the earlier research that's being done on radon, so I think it's fair to say that the thinking regarding the contribution that radon makes to cancer morbidity/mortality is in flux.

I think that the general medical opinion today is that it's better to err on the side of caution, and if you can control radon, to do so. However, we're fortunate, Counselor, here in Indiana that the radon levels are relatively low compared to other states.

Q That's your opinion, isn't it, Doctor, and you so testified in your deposition that in the

state of Indiana radon can be a contributing cause of lung cancer?

A If you're asking me is it possible, my answer is yes.

Q I'm sorry, I was asking whether or not it's your opinion that here in the state of Indiana radon can cause lung cancer. That's what you testified to in your deposition, didn't you, sir?

A I don't remember the exact words, but I think I've answered your question. I think it can be a contributing factor.

Q Okay. Thank you. Doctor, would you agree with me that factors that cause lung cancer in nonsmokers can also cause lung cancer in smokers?

A Factors that cause lung cancer in nonsmokers can cause lung cancer -- sure. If you have a patient that has an exposure to a particular toxic chemical that induces a mutation in the cell or if you have a patient that has a particular hereditary predisposition to one of the rare types of cancers like angiosarcoma,

that can occur in a patient who smokes, but it's very, very unusual. But, sure, it can happen.

There is a rule in medicine, Counselor, you never say always or never. There are always some exceptions to the rule.

Q Let me shift our focus here for just a moment, Dr. Myers. Let's talk for a moment about smoking cessation in general.

A All right.

Q You agree, do you not, that smoking cessation has major and immediate health benefits for men and women of all ages?

A Yes, I think that's a fair statement.

Q And it's also your opinion and you agree with the statement that the risk of a person contracting lung cancer decreases significantly within five to ten years of stopping smoking?

A It certainly does go down, and that's exactly the reason we want patients to stop smoking to reduce their risk. Unfortunately, it never gets to zero.

Q You also agree, don't you, Doctor, that for

most smokers who stop smoking, after 15 to 20 years that their risk of lung cancer is only slightly above that of the population that never smoked?

A I think that's a fair statement of the literature. Fifteen to twenty years of zero smoking and nonexposure to others as secondary smoke can bring your risk down substantially. Never equalling nonsmokers, but getting as close as possible.

MR. WAGNER: Okay, thank you, Doctor.

THE COURT: Further cross exam?

MR. SHEFFLER: No questions, your Honor.

MR. KEARNEY: No questions, your Honor.

MR. HARDY: No thank you, your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION,

QUESTIONS BY MR. MICHAEL W. HOLLAND:

Q Dr. Myers, you were asked about whether there

were any questions concerning the precise mechanism by which a healthy cell turns into a cancerous cell and you made your answer.

Does any doubt about that precise mechanism affect your opinion that cigarette smoking is a cause of lung cancer?

A Not at all.

Q Can you explain why?

A Well, precise mechanisms, I mean if you're talking about the biochemical level, what happens from A to B to C to D and the different steps towards a mutated cell, we are not yet able in science to specify each of those interactions within the cell.

But we do know that there is a very strong association between nicotine addiction, cigarette smoking and lung cancer. And you don't have to prove the precise cellular mechanism, in my opinion, in order to know that there is a causal relationship.

Q Doctor, you were asked about your experience and involvement with the hospital which continues. Can you explain how much of your

time is involved in seeing patients?

A I would say -- the shift is about six and a half hours, and I said it's about -- on average twice a month in the emergency room setting. There's some preparation work. Occasionally you'll have to come back to the hospital to check on a lab result or check on an x-ray that wasn't done at the time you left just to make sure of something or other, but. That's in terms of the hours that I physically am there actually taking care of patients with my stethoscope on, that's about it.

There are a number of other hours that I put in to teaching rounds and/or grand rounds where the patient isn't necessarily there but the house staff and students are there.

Q Can you explain why you remain involved in that capacity?

A Because I consider myself a physician first and everything else I do is secondary. I was trained to be a doctor. I think that's very important for me to keep those skills as highly honed as possible, and this is the best way for

me to do it and do the other -- or take care of the other responsibilities that I have on these committees and boards and The Associated Group office.

Q Are you compensated for your work at the hospital?

A No, I am not. I am -- although I'm a clinical associate professor of medicine, all of the money that is billed in my name goes to the university and is donated back by me. I do not -- I do not receive any remuneration from the I.U. Medical Center for the work that I do, nor have I ever.

Q In connection with your work with patients, do you have occasion to see patients who are nicotine addicted?

A Yes.

Q Why is it that you don't tell patients that they can't quit?

A Because you very much want them to do all they can to try to quit. You don't want to defeat them. Sometimes you use sort of the reverse -- what some people refer to as reverse psychology

technique, especially when you get a certain patient type, especially guys, who behave differently in my clinical experience than women who smoke in some cases. You tell them that they can't do something and they'll try to do it just to prove you wrong.

But I never tell anybody that they absolutely, positively can't stop because I want them to do everything they can to stop. As I, I think, I testified to before, I don't really care whether they use mechanism A or B or C as long as we get to the point where they are no longer ingesting nicotine and they get that -- see, what happens, of course, when you take nicotine, the studies have shown that it stays in your body for a long period of time, so you smoke and the nicotine stays there for 24 hours or longer and starts coming down and then they start smoking again. You don't want that.

You've got to break that cycle in some way to get it down and have it stay down. Any way they can do that to get past that difficult

point, I want them to try to do.

Q Doctor, you were asked whether all smokers lack voluntary control over their smoking and you answered no. Are there some smokers who do lack voluntary control over their smoking?

A There are many who do, as evidenced by the fact that a third to a half of the people in any given population try to quit each year. They know the health consequences. They know that it's harming the environment in their homes. They know that it's something that they shouldn't do for a variety of reasons, and they try to quit and they can't, because they're addicted. Those patients haven't been able to find the mechanism to overcome their addiction.

Q Doctor, you were asked about your own smoking in the past. Could you explain how much you smoked?

A On average, it was never more than two or three cigarettes a day. I was highly embarrassed by the fact that I continued to do that. I hid it from everyone that I could hide it from. I know that that was -- I knew that that was the

wrong thing to do, yet I guess it proved that I was a human being as well, and I ultimately made the decision to do the right thing, and fortunately I have been very successful since that point in time in that arena.

Q Doctor, you were asked whether you are a psychiatrist. Is addiction the exclusive province of psychiatry?

A If it was, then very few people would ever get help, because there are so few psychiatrists that see so many of the patients that are addicted to nicotine and other drugs. In fact, I would suggest to you, Counselor, that the majority of people that are addicted to heroin, other opiates, cocaine and so on, see internists, emergency room physicians and family practitioners primarily and not psychiatrists. I think the same holds true with nicotine, although clearly psychiatry has a role for some patients, and for some patients, if they think that's going to help them, I'm the first one to sign the referral form to get them that help. But there are not

enough psychiatrists to go around. They cost money. A lot of the insurance plans unfortunately don't cover that for a variety of reasons, and therefore it falls to the family practitioner, the internist and the emergency room docs.

Q Doctor, I am going to show you what's been marked as Plaintiff's Exhibit 10 and ask you if you can identify that.

A This is the most recent version of my curriculum vitae.

MR. MICHAEL HOLLAND: At this time, plaintiffs would offer Plaintiff's Exhibit 10.

MR. WAGNER: Mike, is there any difference between this one and the --

MR. MICHAEL HOLLAND: No, it's the same one.

MR. WAGNER: We have no objection.

THE COURT: Show Plaintiff's Exhibit 10 -- I guess just Exhibit 10, it should be, admitted into evidence.

MR. MICHAEL HOLLAND: May I pass it to the jury? And I have a picture as well.

THE COURT: Yes, great. Thank you.

MR. MICHAEL HOLLAND: That's all we have.

THE COURT: Recross, Mr. Wagner.

RECROSS EXAMINATION,

QUESTIONS BY MR. RICHARD D. WAGNER:

Q Just a couple of brief questions, Doctor.

A There's a mistake here.

Q I'm sorry.

A Well, just a minor one. I'm just looking at this, my daughters -- I mean the ages of my kids have gone up.

Q That's a problem, Doctor, that we all have.

A Yes.

Q Especially as they approach college and all those things. Just a couple of questions, Doctor.

A All right.

Q You told me during my examination that motivation of someone who attempts to quit is a

very important factor; am I right?

A Yes, Counselor, it is.

Q And I think -- and I tried to make a very careful notes here during Mr. Holland's questioning of you, and I believe you said that there were several different methods that could be used by people who wanted to smoke; they could just quit cold turkey or other methods, and you said that they all have some usefulness in quitting smoking, right?

A I believe so, yes.

Q And you said if one doesn't work, you keep pushing, right?

A Yes, sir.

Q As my note says, because one of the methods can and will work, right?

A That's what we want the patient to believe.

Q And you said one of the methods can and will work, right?

A If that's what the transcript says, then I said it.

MR. WAGNER: Thank you.

MR. MICHAEL HOLLAND: Doctor, are

there smokers with whom --

MR. KEARNEY: Your Honor, I've got some recross.

THE COURT: Oh, I'm sorry, so does Mr. Holland. Yes, you may proceed.

MR. KEARNEY: I know I'm quiet over here in the corner.

RECROSS EXAMINATION,

QUESTIONS BY MR. JAMES V. KEARNEY:

Q Very, very briefly, Doctor. You gave some testimony in answer to Mike's questions about people who try to stop smoking and can't. You said there was a large number of people who try to stop smoking and can't.

Am I correct that you were a person who smoked and then you stopped, correct?

A Yes, that's correct.

Q Then you started again?

A That's correct.

Q So you were one of these people who stopped for a period of time and then went back to smoking; am I correct?

A That's correct, but the difference is I wasn't

addicted.

Q Okay. Now, let me ask this question. So you were not one of these people who you would say could not stop smoking; is that right?

A That's correct.

Q When you went back to smoking, it wasn't because you couldn't keep abstinent, if you will, is that right? You just chose to go back to smoking; am I right?

A Well, could you ask that question again? Let me hear your words one more time.

Q Okay. The issue is whether or not people who go back to smoking, go back to smoking because they can't keep abstinent or because they don't want to keep abstinent.

My question to you is this: You were a smoker, correct?

A Correct.

Q You quit?

A Correct.

Q All right. Then at some point in time you decided not to keep abstinent, you decided to smoke again; am I right?

A That is correct.
Q You would not characterize yourself as a person who could not quit; am I right?
A That is correct.
Q One other question. Those people who you say try to stop and they can't, you agree with me that some of those people when they try again do in fact quit and quit permanently; isn't that right?
A Absolutely, yes, that's true.

MR. KEARNEY: No further questions.

THE COURT: Any further recross? No?

REDIRECT EXAMINATION,
QUESTIONS BY MR. MICHAEL W. HOLLAND:
Q Doctor, are there certain patients who are addicted and who despite their best effort are unable to quit?
A Yes.

MR. MICHAEL HOLLAND: Thank you.

THE COURT: Recross? Further questions, defendants?

RECROSS EXAMINATION,

QUESTIONS BY MR. RICHARD D. WAGNER:

Q It's all a matter of motivation, isn't it, Doctor?

A No, it's not all a matter of motivation, Counselor. It's a matter of addiction. That's the difference. And if you'd like for me to explain further, I'd be pleased to.

MR. WAGNER: Thank you, Doctor.

THE COURT: Further questions? Plaintiff?

MR. MICHAEL HOLLAND: No, your Honor.

THE COURT: Defendants? Thank you, Dr. Myers. You may step down.

Counsel, approach the bench for a scheduling conference, please.

(A discussion was held off the record.)

THE COURT: We're going to break for lunch at this time, and Shelly has been trying feverishly to get you reservations at the Aluminum Room. No, I guess that's not right. She'll tell you what that is.

So we're going to take a break now for lunch, and because we're being allowed to separate, please remember your admonition, you're not to discuss this case among yourselves or permit it to be discussed with you by anyone. You're to continue to keep an open mind until you've herd all the evidence, final instructions and the final arguments of counsel.

With that, the jury may rise, you may retire, and we'll be in recess until 12:50.

(At 11:43 a.m., the trial proceedings recessed, to reconvene at 12:50 p.m.)